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Mark E. Souder
Chairman
Subcommittee on Criminal Justice
Drug Policy and Human Resources
Committee on Government Reform
2157 Rayburn House Office Building
Washington DC 20515-6143

March 30, 2004 Hearing
Measuring the Effectiveness of Drug Addiction Treatment
Subcommittee on Criminal Justice
Drug Policy and Human Resources

Dear Mr. Chairman,

In further response to the questions posed I am pleased to provide the following;

(Question 6) Mr. O'Keeffe testified that Federal policy is not optimal for the development and deployment of new treatments. What policy changes do you think would encourage that development?

As I noted in my testimony, enactment of the Drug Addiction Treatment Act (DATA) went a long way toward increasing access to treatment and improving the outlook for the future, through the Act's recognition that drug addiction is a disease that requires the attention of specialty physicians and other health care providers and the ability of those providers to offer treatment in the setting of their own clinical practice. The intent of Congress to ensure that this new approach to addiction treatment was implemented in a careful way, to avoid diversion and abuse of the treatments themselves, was appropriate. However, it had an unintended consequence that has prevented this important statute from reaching its full potential.

The law required not only that providers certify to the Secretary of Health and human Services that they are qualified, by reason of training and experience, to provide addiction treatment, but also that they would limit that treatment to 30 patients at a time. The law expanded that 30-patient limitation so that it applies not only to each individual practitioner but also to every group practice. The unintended and unfortunate result of this is that group practices with dozens, or hundreds, of practitioners are limited to treating the same number of patients – 30 – as each physician in a solo practice. Thus, patients who receive their care from providers in group practices are less likely to be able to receive the addiction treatment envisioned by the DATA. All of the physician members of the group practice are limited, together and in the aggregate, to treating no more than 30 patients at a time.

Interestingly, this problem exists not only for organizations we may think of in the traditional sense as "group practices" – ranging is size from small groups of 5 or 10 physicians to those such as Kaiser Permanente or Aurora, for example, but also at academic health centers affiliated with medical colleges, whose physicians are all members of the same "group practice." Thus, even these health care settings – which frequently offer some of the most cutting-edge health care in the country – find themselves hamstrung as regards the treatment of drug addiction. Nearly all of the clinical research conducted prior to approval of drugs covered by DATA was conducted in medical centers associated with medical colleges such as Yale, Columbia, U.C.L.A., Wayne State, and many more, yet these same centers of medical excellence are precluded by DATA from treating more than 30 patients at one time.

It clearly was not the intention of the DATA that addicted patients have less access to new medications simply because they receive care from a physician practicing in a group, or from a group-based or mixed-model health plan. Nevertheless, this effect is being felt today. The problem can be addressed by removing the 30-patient aggregate limit on medical groups. Such a change would enhance the new treatment paradigm established by DATA and, since the patient limitation would remain on individual treating physicians, would not increase the potential for abuse or diversion.

While the law allows for the Secretary of HHS to change the patient limitation by regulation, this is a most cumbersome and lengthy way to improve policy. Congress, however, has introduced several bills to change this inadvertent requirement. Enactment of that legislation (e.g., H.R. 3624, S. 2976) would correct it and ensure the policy works the way it was intended.

(Question 7) How do you get patients in denial into treatment?

For many years patients have resisted entering treatment for a variety of reasons including denial. In many cases, this denial resulted from fear of admitting that their drug use was inappropriate. Often these patients were reluctant to address the problem because of the stigma associated with the disease and their inability to have their disease addressed in the normal course of the practice of medicine, and their unwillingness to participate in drug treatment programs often located in unsafe and/or drug infested areas of inner-cities. For the past forty years physicians have been precluded from treating these patients in the privacy of their offices with the pharmaceutical products and treatment methods shown to be effective for opiate dependence. The Drug Addiction Treatment Act (DATA) established a new treatment paradigm which offers new opportunities for those patients to seek treatment. SAMHSA Administrator Currie has addressed the "treatment gap" identified by the White House Office of National Drug Control Policy, and that agency has moved expeditiously toward bringing more patients into treatment following enactment of this legislation. They have developed Guidelines for this new office-based treatment paradigm and more and more patients are entering treatment as a result of this congressional action. Unfortunately, many patients are still being denied treatment because their only source of medical care is clinics operated by medical schools, or large group practices that are currently precluded from treating more than 30 patients per institution because of the unintended effect of language of the DATA.

In a sense, the legislation which opened the door to treatment for so many has inadvertently prevented untold thousands of patients from receiving treatment they seek. Legislation such as that discussed during this hearing (H.R. 3624, S. 2976) will remove this unintended impediment and provide access to treatment to those currently seeking it but being denied acces to it because

of the patient ceiling inadvertently imposed on group practices. Providing acces to treatment for all treatment-seeking patients will significantly alleviate much of the fear and denial so often encountered in these patients.

Other witnesses are more qualified to respond to the other questions posed.

If I may be of further assistance to the Committee, please do not hesitate to contact me.

Sincerely,

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